TRICARE Pharmacy Program Medical Necessity Form for Eprosartan (Teveten) & Eprosartan/HCTZ (Teveten HCT)

This form applies to Military Treatment Facilities (MTFs), the TRICARE Mail Order Pharmacy (TMOP) and the TRICARE Retail Pharmacy Program (TRRx). It must be completed and signed by the prescriber. This form may be found on the TRICARE Pharmacy website at www.tricare.osd.mil/pharmacy/medical-nonformulary.cfm.

Teveten and Teveten HCT are designated as non-formulary medications on the DoD Uniform Formulary. **Formulary alternatives in the same drug class available at a $9 cost share include Atacand, Avapro, Benicar, Cozaar, Diovan, Micardis and corresponding combinations with hydrochlorothiazide (HCTZ).**

- **Spouses, family members, and retirees** do not need a medical necessity determination in order to fill prescriptions for Teveten or Teveten HCT at the $22 non-formulary cost share through retail network pharmacies or mail order. They may fill prescriptions for non-formulary medications at the lower formulary cost share ($9) if the non-formulary medication is determined to be medically necessary.
- **Active duty service members** may not fill prescriptions for a non-formulary medication unless it is determined to be medically necessary. If the non-formulary medication is determined to be medically necessary, active duty service members may fill prescriptions at $0 cost share.

MTF	MAIL ORDER	RETAIL
• Non-formulary medications will be available at Military Treatment Facilities (MTFs) only if both of the following are true: ▪ The prescription is written by a military provider or, at the discretion of the MTF, a civilian provider to whom the patient was referred by the MTF. ▪ The non-formulary medication is determined to be medically necessary using the medical necessity criteria outlined on this form. • Please contact your local MTF for more information. • There are no cost shares at MTFs.	**If the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here** ☐ • The completed form and the prescription may be **faxed** to **1-877-283-8075** or 1-602-586-3915 **OR** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**	**If the prescription is to be filled at a retail network pharmacy, check here** ☐ • The provider may **call**: **1-866-684-4488 OR** • The completed form may be **faxed** to **1-866-684-4477**

There is no expiration date for approved medical necessity determinations.

Step 1

Please complete patient and physician information (Please Print)

Patient Name: _____
Address: _____
_____
Sponsor ID # _____

Physician Name: _____
Address: _____
_____
Phone #: _____
Secure Fax #:

Step 2

Please indicate which of the reasons below (1-4) applies to each of the formulary alternatives listed in the table. You MUST supply a reason AND a specific written explanation for EACH formulary alternative.

Formulary Alternative	Reason	Explanation
Atacand/Atacand HCT		
Avapro/Avalide		
Benicar/Benicar HCT		
Cozaar/Hyzaar		
Diovan/Diovan HCT		
Micardis/Micardis HCT		

Acceptable clinical reasons for not using each of the formulary alternatives are:

1. Use of this formulary agent is contraindicated.
2. Patient has experienced significant adverse effects from this formulary agent.
3. Use of this formulary agent at therapeutic doses and duration has resulted in therapeutic failure.
4. Patient has previously responded to Teveten/Teveten HCT and changing to this formulary agent would incur unacceptable clinical risk (e.g. severe complication or hospitalization). Explain the unacceptable risk.

Step 3

I certify the above is correct and accurate to the best of my knowledge. Please note: By completing and signing this document you are confirming that the patient has either tried ALL of the formulary alternatives to Teveten/Teveten HCT or has a clinical reason(s) for not trying ALL of the alternatives. Please sign and date:

_____ _____
Prescriber Signature Date

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